

3:2 Target Article authors respond to Commentators How Not to Argue About Circumcision

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A *target* article can be expected to draw fire. As our Target Article, “Between Prophylaxis and Child Abuse: The Ethics of Neonatal Male Circumcision,” defended an intermediate position on circumcision, one would have expected the fire to come from two directions. However, the criticism was entirely one-sided. None of our respondents were defenders of routine neonatal circumcision. By contrast, those who take circumcision to be mutilation and child abuse were amply represented. There are a number of possible explanations for this, but one of these is that those who oppose circumcision are more vocal because they have coalesced into an activist movement.

Although opponents of circumcision took aim at our arguments (or, more likely, at our conclusion), they missed their mark by far. They have given a fine display of how not to argue – about circumcision, or anything else. Non-sequiturs, appeals to authority, anecdotes, equivocations, question-begging, and many more such errors abound in their replies. In our response, we shall highlight these and other errors and show how these respondents have utterly failed to engage our arguments.

Not all the commentators on our paper were critical of what we said. Some treated our paper as a departure point for taking the issues further. Rebecca Dresser, for example, shows how our analysis, which maps out the realm of parental discretion, is also relevant to family decisions for incompetent adults (Dresser 2003). Dena Davis extends our treatment of cultural bias in attitudes to comparable male and female genital cutting, with a discussion of the relevant United States law (Davis 2003). John Paul Slosar and Daniel O’Brien show how our analysis is compatible with a Catholic perspective (Slosar and O’Brien 2003). These, and some others, are all helpful contributions to the discussion and we are grateful for them. Our focus, however, will be on those respondents who disagreed with us.

Mutilation

Some of our respondents, in claiming that neonatal circumcision is mutilation, make the very errors that we exposed in our original paper. Petrina Fadel, for example, cites the American Heritage Dictionary definition of “mutilate”: “1. To cut off or destroy a limb or essential part. 2. To render imperfect by excising or radically altering a part” (Fadel, 2003, W-2). The connection between (a) this definition and (b) what she then says is lost through circumcision, is not made explicit. We assume she thinks that the removal of the foreskin, which she calls “a protective and sexual organ”, is the cutting off of “an essential part” or the rendering “imperfect by excising ... a part”. However, this begs the question. It assumes that the foreskin is indeed an essential part and that excising it renders

the penis imperfect. Simply calling the foreskin a “protective and sexual organ” is not a substitute for the careful analysis we recommended and undertook regarding whether circumcision is beneficial, harmful or neither. For instance, as should be clear from the evidence we presented, it is far from clear that the foreskin “protects the sterile urinary tract environment” (Fadel 2003, W-2). There is some evidence that the foreskin may rather constitute a modest threat to the sterility of that environment, as evidenced by the slightly higher rates of urinary tract infection in the uncircumcised. It is stunning that, in response to a careful presentation and analysis of the evidence, this commentator believes it will suffice simply to assert a contrary conclusion.

Both Michelle Mullen (2003) and J. Steven Svoboda (2003) take exception to what we say, in our discussion of mutilation, about such surgical procedures as breast reduction, liposuction and rhinoplasty. They deny that these are analogous to infant circumcision because the latter is performed without the patient’s consent, whereas the former cosmetic surgeries are performed with consent. This objection is off the mark – not because these procedures are analogous with respect to consent, but because the consent issue is entirely irrelevant to the point we were making. We referred to breast reduction, liposuction and rhinoplasty to illustrate the point that not every appearance-altering surgery constitutes mutilation. Consent is irrelevant to *that* (limited) point – unless one believes that all non-consensual appearance-altering surgery constitutes mutilation. On this latter view, reference to a lack of consent would have to be incorporated into the definition of “mutilation”. But this stipulation would depart substantially from ordinary usage and would be susceptible to counter-examples.

Michelle Mullen also takes exception to our reference to the amputation of a gangrenous leg (2003). She denies that this is analogous to circumcision because a gangrenous leg, unlike an ordinary foreskin, is not healthy tissue. Here again, however, she is inattentive to the particular point we were making. Our claim was that disfiguring surgery can be morally justified even if it constitutes mutilation. Thus, demonstrating that a procedure constitutes mutilation is insufficient to show that it is morally wrong. Further argument is necessary. Perhaps Dr. Mullen thinks that such an argument would include a premise that all (non-consensual) disfiguring surgical removal of *healthy* tissue is wrongful mutilation. But to this it might reasonably be objected that *if* the disfiguring surgical removal of healthy tissue were to bestow a net benefit on the person on whom the procedure is performed, it is highly implausible to claim that the mutilation is wrongful. Dr. Mullen may think that there can be no such benefit, but that is a

matter to be established by argument rather than by stipulative definition.

Nicholas Lund-Molfese objects to the definition of “mutilation” that we discussed. He takes that definition to be a “neutral physical description devoid of ethical conclusions” and prefers instead a value-laden definition, such that the word “mutilation” cannot be employed except in cases where the referent is morally wrong (Lund-Molfese 2003, 64). A few observations are in order here. First, the definition of mutilation to which we referred was not entirely value-neutral. It incorporated the notion of “disfigurement”, which, we noted, was value-laden. Second, value-laden definitions have their advantages, but also their disadvantages. One of the latter, at least where the relevant value is moral in nature, is that a moral judgment has to be made before the definiendum can be used in reference to some practice. Put another way, in the context of circumcision, a morally value-laden definition of “mutilation” cannot be used in reference to circumcision unless one has already established that circumcision is wrong. To establish that circumcision is wrong, one cannot simply describe circumcision as mutilation (which would be circular).

George Hill adopts a different approach. He says that the relevant question is not whether circumcision is “mutilation”, but whether parents may decide to remove “extremely sensitive genital tissue from an infant for any reason other than unquestionably urgent medical necessity” (Hill 2003, W-1). We argued that the mutilation question is indeed *not* the relevant one. And we agree with Dr Hill’s assessment of what the relevant question is. Unlike Dr Hill, however, we do not think that merely asking the question constitutes an answer to it. Our entire paper was devoted to considering the relevant evidence and arguments that must be examined in order to answer the question. Simply re-asking the question does not undermine the outcome of that deliberative work.

One of our respondents, Wayne Hampton, makes the same sorts of errors in speaking about “child abuse” as other respondents made in speaking about mutilation. He says that “permanent injury is part of the definition” of “child abuse” and that since circumcision involves permanent injury, it constitutes child abuse (Hampton 2003, W-1). However, not all permanent injuries inflicted on a child constitute child abuse. If a child with a gangrenous foot has this limb amputated, the surgeon inflicts a permanent injury on the child, but it does not follow that the surgeon abused the child. This is because some injuries – damage to tissue – do not constitute a harm, all things considered.

Informed consent

In our paper we considered (and rejected) the view that circumcision must be wrong because it is a medically non-essential procedure to which neonates are unable to consent. A number of our respondents simply repeated this view without engaging or undermining the arguments we advanced for its inadequacy. This is not progress, but is instead reassertion.

For example, Paul Ford simply asserts that “surgery is impermissible *for incompetent patients* unless it offers clear and significant net *medical* benefits” (Ford 2003, W-1). Rio Cruz and colleagues are happy merely to reassert that an “individual’s right to bodily integrity” may not be abridged unless there is “compelling, rational, demonstrable benefit” (Cruz et al. 2003, W-1). These restatements of the view we reject, ignore the arguments we provided for an alternative view. We defended the view that parents have the right to authorize some medical interventions for their children even in the absence of clear and immediate medical necessity – generally, those (possibly beneficial) medical interventions that are not clearly harmful, particular if they yield some other (non-medical) benefit.

Our argument invoked the analogy of vaccination which, where herd immunity obtains, does not clearly provide a benefit and does carry small but serious risks to any individual child that is immunized. Wayne Hampton denies that vaccination is analogous (Hampton 2003, W-2). First, he says, it constitutes a gain, rather than a loss. This claim is ambiguous. If by “gain” and “loss” are meant “benefit” and “harm”, then his claim begs the question. If, instead, he means literally an addition (of biological material) and a loss (of genital tissue), then it may be countered that this gain-loss distinction is morally uninteresting. Poison may be added and malignancy may be removed. But gaining poison is clearly morally worse than losing a malignancy. Clearly it is not gain and loss but rather benefit and harm that are of interest. However, nothing Wayne Hampton says undermines the analogy, in this regard, between circumcision and vaccination.

Steven Svoboda has different objections to the vaccination analogy. First, he says, the public health benefits of circumcision are “incomparably miniscule compared to” those of immunization (Svoboda 2003, 53). Here we see that Mr. Svoboda chooses to compare the *public* health benefits of circumcision and immunization. Our analogy, however, was between the *individual* health benefits of the two interventions (because we were not defending *routine* neonatal male circumcision). More specifically, we compared the benefits of circumcision to an individual with the benefits of immunization to an individual where herd immunity obtains (and thus the public health benefit has already been secured). It is true that circumcision does differ from immunization, as he says, in that “circumcision constitutes a much more serious invasion of the individual’s body” (53). However, two considerations are relevant here. First, even if circumcision is more invasive than vaccination, it does not follow that it is excessively invasive. (Notice that a vaccination administered by injection is in turn more invasive than an orally administered vaccination.) Second, the severity of this invasion has to be weighed against the potential benefit, and the benefit of circumcision to an individual *may* be greater than the benefit of immunization is to that individual where herd immunity obtains.

Mr. Svoboda offers what he takes to be a better analogy to circumcision – prophylactic double mastectomy of

girls whose family history suggests that they are at high risk for breast cancer (2003). He argues that although such mastectomies would much more likely save lives, nobody seriously suggests that such prophylactic surgery be performed (on young girls). However, this analogy is not very compelling. The psychological effects of performing double mastectomies on girls would generally be considerably worse than (a) performing this procedure on adult women; and (b) circumcising infant males. Put another way, *if* one were to have prophylactic mastectomies, most people would prefer to have them later in life, whereas *if* one were to be circumcised most people would prefer to have this done in the neonatal period.

Paul Ford correctly notes that “a neonate still has to develop his own values and choices” (Ford 2003, 58) but seems to think that because informed consent cannot be obtained from the neonate, non-therapeutic circumcision must therefore be wrong. But again, this simply constitutes an unsubstantiated rejection of a conclusion for which we *argued* – that parents may, subject to certain constraints, make decisions on behalf of their incompetent offspring.

Wayne Hampton charges us with seeing “no value in a patient’s personal autonomy and freedom of choice” (Hampton 2003, W-1). But this ignores the complexities generated where patients do not yet have the capacity for autonomy. Decisions sometimes have to be made on behalf of such patients. It is true that the future autonomy of a currently incompetent patient must be a guiding value. This, however, does not constitute a decisive consideration against circumcision. First, what evidence there is for the beneficial nature of circumcision suggests that the benefit is greatest when circumcision is performed in infancy.

Second, it is far from clear that non-circumcision leaves open a future person’s options in every regard. It does preserve the option of future circumcised or uncircumcised status. But it makes other options far more difficult to exercise. Transforming from the uncircumcised to the circumcised state will have psychological and other costs for an adult that are absent for a child. Steven Svoboda (2003) misunderstands what these costs are. The relevant cost here is not pain – a problem that can be adequately resolved by appropriate analgesia in both children and adults. Instead the relevant costs can include (1) the embarrassment of having one’s genitals exposed and operated upon, (2) having one’s genital alteration become the subject of curiosity and discussion by one’s acquaintances and co-workers; (3) the possible difficulties of adapting to the new appearance of one’s genitals (no matter how much one wants the change), and (4) a recovery period that interferes with the pursuit of one’s other projects. An infant suffers no embarrassment from circumcision, has none of the anxieties of a knife being taken to his penis, is immune to gossip, has no difficulty adjusting to the new appearance of his genitals, and does not need to take off time from work (or school) to recover.

Given the costs of adult circumcision, many uncircumcised adult males who would wish to be connected with religious and cultural communities in which circumcision

is a central tenet would have circumcision stand in the way of their exercising this option. These men would face a significant obstacle to religious and cultural expression. Critics of circumcision might wish to dismiss this impediment by noting that such men would still have the *option* of religious and cultural affiliation by undergoing circumcision. This retort is too quick, however. Consider the following analogy. Many people, presumably including many opponents of circumcision, support compulsory primary and secondary education for children. Those children who elected not to go to school would be able, later in life, to gain the education they had missed, if they decided to pursue a career that required a higher level of education than that which they had obtained. So their option for education would be preserved if primary and secondary education were not compulsory, and their autonomy would thereby be respected. Yet it is clear that an adult’s choices would be severely constrained, in practice, if he or she lacked primary or secondary education. Now rectifying an education deficit would certainly take much more time and effort than would subjecting oneself to circumcision, and thus we are not suggesting that these two constraints on options are equally strong. All we are suggesting is that being uncircumcised can limit options in practice and thus erring on the side of a child’s autonomy is not without cost.

Nor are these costs “negligible”, as Wayne Hampton (2003, W-1) suggests they are. (A fortiori, they are not “zero” as he elsewhere says they are.) At the very least, they are not more negligible than the risks and costs of circumcision. Wayne Hampton’s claim that the negligible costs of waiting are preferable to “making a permanent ethical mistake” (2003, W-1) is question-begging.

Costs and Benefits

Mark Sheldon correctly notes that much of our argument about circumcision depends on whether the empirical evidence about the medical costs and benefits of circumcision is as we suggest it is. Had the risks and harms of circumcision been much greater, and if there were clearly no benefits, then the balance of considerations would have been against circumcision. Mark Sheldon does not take issue with our presentation of the actual evidence, which he describes as “dispassionate, thoughtful and apparently fair” (Sheldon 2003, 61). Indeed we attempted to present the evidence as clearly and as fairly as possible. Some of our respondents, however, have taken issue, either explicitly or implicitly, with our discussion of the costs and benefits.

Steven Svoboda criticizes our analysis of the costs and benefits of circumcision for “ignoring the elephant in the room – the inherent value of the intact penis” (Svoboda 2003, 53) What he fails to realize, however, is that the very point of contention is whether there is indeed an elephant in the room or whether this pachyderm is instead an artifact of circumcision opponents’ virtual reality. In other words he begs the question. The value of an intact penis cannot be fully assessed without knowing the benefits and costs of a circumcised penis. It will not do simply to

assume the value of the intact penis.

Wayne Hampton accuses us of not doing a proper calculation of the costs and benefits of circumcision (Hampton 2003). He seems to think that we underestimate the risk of death and dismemberment by noting the infrequency of these complications. On his view, *any* risk of death or dismemberment, no matter how small, is unacceptable. But this trumping weight can be granted to rare death and dismemberment only if there are no benefits to be derived from circumcision. Once there are some benefits, the complications need to be weighed against these. Then the rarity of the complications becomes relevant. Wayne Hampton also seeks support for his claim that we underestimate the costs of circumcision, by referring to the elevated risks of death and dismemberment characteristic of traditional Xhosa circumcision. But it is manifestly inappropriate, when considering risks and costs, to compare the practice of infant circumcision in sterile conditions by trained professionals, with circumcision of youths by inadequately trained tribal figures in non-sterile conditions. It is thus he, not we, who is doing the mathematics incorrectly. Moreover, he ignores our argument that a cost-benefit calculus is not simply a matter of weighing medical evidence. Personal values affect the equation. Thus, for example, it is not unreasonable for somebody to rank the death and morbidity (from penile cancer) of an adult as worse than the death (from circumcision) of an infant who may be less invested in his life. The point here is not that we must rank the costs in this way, but that a ranking (one way or the other) involves not only medical but also value judgments.

George Hill claims that we say more about the benefits than the costs of circumcision (Hill 2003). This makes it seem as though we devote disproportionate space to outlining the benefits. However, discussing the alleged benefits is not the same as defending the view that these really are (significant) benefits. Much of our discussion of the benefits was directed to the limitations of the evidence of benefit. Similarly, our discussion of the costs included an assessment of whether the alleged costs were real, how great they were and whether they could be avoided.

Pain

George Hill (Hill 2003, W-1) complains that we ignore post-operative pain. But we did discuss this. We indicated that we “are not aware of any studies on such pain and its control in neonates” but that there “seems to be no reason ... why simple topical or systemic analgesics should not suffice”. Michelle Mullen acknowledges that we discuss post-operative pain, but dismisses our arguments by saying that although there may be no studies, “there is a *prima facie* case to suggest that scalpel wounds to the genitals which are then exposed to regular coatings of urine and feces (a diaper) would be painful” (Mullen 2003, 49). This response misses the point. We agree that there will be post-operative pain. In fact, there is more than a *prima facie* case for thinking that there will be such pain. The relevant question, though, is whether that pain can be controlled.

Given that postoperative pain can be well controlled for much more radical surgical procedures, it is reasonable to assume that it can be adequately controlled after circumcision.

Both George Hill (Hill 2003) and Michelle Mullen (Mullen 2003) also criticize our failure to discuss those papers that suggest that inadequately controlled pain in infancy leads to greater pain perception later in life. In offering this criticism they ignore how its force rests on the *inadequate* control of pain. We indicated that circumcision should not be performed without adequate pain control, both intra-operatively and post-operatively. If the analgesic condition is met, then the concern about after-effects of inadequately controlled pain from circumcision simply does not arise.

Michelle Mullen seeks to elicit her readers’ disapproval of employing (the most effective forms of) analgesia – penile nerve blocks – by graphically describing this as “sticking needles into small neonatal penises” (Mullen 2003, 49). This rhetorical trick obscures the evidence (Kirya 1978; Stang 1988, and Williamson 1983) we cited that “the administration of the injections themselves have not been found to elicit a pain response” (Benatar and Benatar 2003, 38).

Frances Batzer and Josh Hurwitz seem more confused. They state that the “seminal issue of inflicting pain in a newborn is important” and reassure their readers that the “technique of dorsal penile nerve block ... appears to be effective” (Batzer and Hurwitz 2003, W-1). However, in the same paragraph they go on to say that it “is a misconception that amputating the foreskin causes pain” (Ibid). If that latter claim were true, one wonders in what way penile nerve block is “effective”.

Sexual pleasure

A number of our respondents claim that sexual pleasure is diminished as a result of circumcision. In doing so, they ignore our earlier arguments against this claim. Rio Cruz and colleagues, for example, are content to tell us how richly innervated and vascularized the foreskin is and that removing it “deprives an individual ... of the full range and depth of sexual pleasure” (Cruz et al. 2003, W-1). However, as we noted in our paper, it does not follow from the fact that the prepuce is highly innervated and vascularized, that removing it diminishes sexual pleasure. This is because more than enough erogenous tissue may remain to facilitate the same degree of sexual pleasure. It is possible that additional increments of erogenous tissue do not increase sexual pleasure. Thus, it is a misrepresentation of our view to suggest, as Wayne Hampton does, that we claim that men are only “entitled to” the penile innervation of the circumcised penis (W. Hampton, 2003, W-1). The language of “entitlement” is a red herring here. It should also be apparent that we do not, as George Hill claims, *ignore* the “loss of the most heavily innervated tissue in the male genitals” (Hill 2003, W-1) Rio Cruz and colleagues say that it “should be self-evident that cutting off primary sexual tissue unalterably changes the way sexual acts are

perceived and performed” (Cruz et al. 2003, W-1) and that we therefore bear burden of proof that we fail to provide (Cruz et al. 2003, W-1). However, it is far from obvious that circumcision reduces sexual pleasure. As our original paper provided evidence of this, we did in fact meet any burden of proof they may think we bear.

Petrina Fadel says that circumcision “is documented to cause erectile problems, a serious impairment of function” (Fadel 2003, W-1) One of the papers she cites, by John Coursey and colleagues, does not support this conclusion. In this study, erectile function was evaluated following anterior urethroplasty and therapeutic circumcision and compared with recollected function prior to surgery (Coursey 2001). While a minority of patients in each group reported dissatisfaction with erection, the substantial majority of men (about 70%) reported either no change or an improvement in erectile function. The second study she cites, performed by Kenneth Fink and colleagues (Fink et al, 2002), investigated the effect of circumcision on erectile function, penile sensitivity, sexual activity and overall sexual satisfaction. The low response rate introduced a potential selection bias and reduced the sample size sufficiently to compromise the reliability of the results. Compared to before therapeutic circumcision, men reported decreased erectile function and decreased penile sensitivity but overall improved sexual satisfaction. Given these apparently conflicting results, and the fact that sexual activity before circumcision was undertaken while suffering from the medical problem that was the indication for circumcision, it is difficult to know how to interpret these findings. What does one make of reduced erectile function in the face of increased overall sexual satisfaction?

Penile cancer

George Hill, in what he obviously takes to be a response to our discussion of penile carcinoma, alludes to a number of countries where circumcision is uncommon and the incidence of this disease is low. He evidently takes this to be a decisive objection to the claim that circumcision offers some protection against penile cancer. However, as we indicated in our paper, this sort of evidence is indirect. Proponents of routine circumcision employ a similar method in reference to a different set of countries in order to prove *their* point. For this reason, we recommended a more direct and therefore more reliable approach to the question of whether circumcision protects against penile cancer. Mr. Hill ignores this more rigorous approach to the question.

Death

Steven Svoboda says we ignore those cases of death resulting from circumcision (2003). However, we do not. We explicitly mentioned the risk of death but indicated that the risk was very low – less than 1 per 500 000 circumcisions. In support of this widely accepted statistic, we cited an article, containing relevant data, in a peer-reviewed journal. Mr. Svoboda sees fit to ignore this, citing instead an opinion piece that makes a claim of 16 deaths per 90 000

circumcisions – a claim that is neither based on presented data nor referenced. Even if we have underestimated the actual incidence of death from circumcision, Mr. Svoboda’s claim of over 200 circumcision related deaths per year in the United States is about a 100-fold greater risk than the best evidence suggests. Mr. Svoboda says that we should focus on the deaths from circumcision rather than on the prevention of penile cancer, which he calls a “vanishing rare condition” (Svoboda 2003, 53). Death from circumcision, however, is rarer still.

Cervical cancer

Not all our respondents thought that we overstated the benefits of circumcision. Armand Antommaria suggests that there is more evidence than we indicated, for the claim that the sexual partners of circumcised men are relatively protected from cervical cancer (Antommaria 2003). In support of this claim, he cites a recent study (Castellsagué 2002), which was published after we had written and submitted our paper. This study does lend some support to circumcision’s protective effect against cervical cancer. It is worth noting, however, that this benefit was identified only in a subgroup analysis of the female partners of those men who themselves had had more than six sexual partners. This study suggests that matters are more complicated than Frances Batzer and Josh Hurwitz think, when they claim that varying cervical cancer rates are (solely?) attributable to “social issues such as the number of sexual partners and ... monogamy” (Batzer and Hurwitz 2003, W-1). Social issues are clearly relevant variables, but it would seem that circumcision status is also relevant.

Financial

Armand Antommaria notes, quite correctly, that the medical costs and benefits are not the only relevant ones (2003). Indeed, our argument considered a number of important non-medical benefits, including cultural ones. The monetary cost of circumcision is relevant to considering the allocation of public health care resources, and thus has bearing on *publicly* funded (especially routine) neonatal circumcision. But the question of whether circumcision may be publicly funded was not one that occupied us in “Between Prophylaxis and Child Abuse”. We doubt that the financial costs, privately borne, could render impermissible the choice of particular parents to circumcise their child. (If they did, then people’s moral freedom to spend their money in a manner of their choosing would have to be severely limited in other ways too.)

Medical associations and medical indications

A number of our critics note that no medical associations recommend infant circumcision. These critics (eg. Cruz et al., Fadel, Hill) either charge us with ignoring this, or they suggest that our conclusions are at odds with the views of these organizations. What these critics have ignored, however, is that *we do not recommend* infant circumcision. In other words, we do not think that it ought to be performed *routinely*. Nor do we recommend against it, however. Our

view is that it is a morally permissible practice.

Steven Svoboda and George Hill seem to ignore the difference between taking circumcision to be permissible and taking it to be preferable, when they attribute to us a position that is ambiguous between these possibilities. Steven Svoboda says that we “come out in favor of the procedure” (Svoboda 2003, 53) and George Hill claims that we offer a “defense” of circumcision (Hill 2003, W-1). These claims could mean that we take circumcision to be morally preferable and that we defend circumcision against those who deny that it is. That is *not* the view we take. We are “in favour” of circumcision only in the sense that we are not opposed to it. Similarly, we “defend” circumcision only against those who think it is morally impermissible. We do not defend it against those who deny that it is morally preferable.

Petrina Fadel makes the overly confident and unsubstantiated claim that there “are no medical indications for circumcision in the newborn period” (Fadel 2003, W-1). Our paper examined the evidence and we concluded that there was *some* evidence of modest medical benefit. Ms. Fadel’s claim would be more plausible if it were that there are no *decisive* medical indications for circumcision in the newborn period. Notice again, however, that one cannot infer from this that circumcision is morally impermissible. Just as there are no decisive medical indications for neonatal circumcision there are also no decisive medical indications against this practice.

Armand Antommara (2003) suggests that if routine neonatal male circumcision is performed for cultural rather than medical reasons then it should not be characterized as a medical procedure and that it might therefore be better for doctors not to be involved. But insofar as a cultural practice has medical value, its being performed for cultural reasons is not incompatible with its being a medical procedure. Thus Professor Antommara’s suggestion presupposes that there are not medical benefits to circumcision, and this presupposition is a point of contention. Notice also, that even if circumcision were thought not to have any medical benefit, it would not follow that there is no sense in which it is a medical procedure. The term “medical procedure” is ambiguous between (a) a procedure performed for medical purposes, and (b) a procedure employing medical means. Even if circumcision were not a medical procedure in the former sense, it could still be a medical procedure in the second sense.

Paul Ford also questions the involvement of doctors in circumcision. He says that even if parents may permissibly have their children circumcised “it does not mean that the medical profession should be involved in the practice” (Ford 2003, 58). Indeed, parental preferences do not commit doctors to being involved. Nor can one infer, however, that doctors should *not* be involved. Paul Ford is correct that the involvement of doctors in a procedure that is exclusively cultural is less easily justified than their involvement in a procedure that also has medical benefits. However, this is not to say that doctors may not be involved in procedures that have only cultural and no med-

ical goals. One possible justification is that doctors will be more expertly equipped to employ the medical means to the cultural end, thereby minimizing the health risks. More would obviously need to be said about this, but we should not lose sight of the fact that circumcision is not clearly an exclusively cultural practice. We argued that there is some evidence for a modest medical benefit. Accordingly it seems reasonable for those doctors willing to perform the procedure to facilitate the preferences of those parents who do wish to have their sons circumcised for its possible medical benefits. Paul Ford says that “physicians should actively discourage the practice and not simply leave it as an unproblematic decision for parents” (Ford 2003, 58) The evidence we presented suggested that there are no grounds for actively discouraging circumcision, just as there are not grounds for actively encouraging it. Our respondents would do well not to draw conclusions that are stronger than the evidence supports.

Parental decision making

Armand Antommara (2003) and Sarah Waldeck (2003) refer to evidence that non-medical considerations are paramount in parents’ decisions to circumcise their children. They take this to reflect negatively on these decisions to circumcise sons. Indeed, it is regrettable that the decision to circumcise (as well as just about every other kind of decision people make) is not informed by all the relevant information and is influenced by inappropriate considerations. This shows that decisions are not made in the right way, but it does not follow from this that the *wrong* decision is made. Sometimes the right decision can be made for the wrong reason and sometimes there may be more than one acceptable decision. We have suggested that circumcision falls into the latter category. Notice too, that the very factors that are said to influence parents’ decisions to circumcise their sons – to resemble their fathers and peers, for example – will influence parents *not* to circumcise their sons in those societies where circumcision is uncommon. Thus Professors Antommara and Waldeck’s comments do not entail the wrongfulness of circumcision (any more than they would entail the wrongfulness of not circumcising in societies where circumcision is rare).

Male and Female circumcision

A number of commentators took issue with our comparison of male and female circumcision. Frances Batzer and Josh Hurwitz suggest that “to equate female circumcision with male circumcision under any guise is ludicrous” because “the ultimate outcome and purpose of each is quite different” (Batzer and Hurwitz 2003, W-1) They seek to assure us that male circumcision “is performed with no intent to inhibit or change sexual or psychological function” whereas female circumcision, they say is “meant to decrease sexual enjoyment” (Batzer and Hurwitz 2003, W-1) What these authors do not realize (but should, because it was mentioned in our paper) is that male circumcision has not infrequently been performed with the intention of curbing sexual desire – the very same justification that has

often been used for female genital cutting. Now, it happens to be false that circumcision has this effect, but it is also false that the *equivalent* form of female genital cutting (as distinct from the more severe form, the effects of which these authors describe) has this effect. Thus we find that the analogy is immune to the criticism of these authors. We explained this carefully in our paper. These commentators have not sought to rebut our argument, but instead ignored it.

Sara Webber and Toby Schonfeld make a similar mistake. They note that female circumcision, the removal of clitoral preputial tissue, has been used for two apparently conflicting purposes – sometimes to curb sexual activity, and sometimes to promote it (in married women). Although this may seem odd, they suggest that these two purposes are explained at a deeper level by an attempt to direct a female's sexuality toward her husband. With this aim, masturbation, premarital and extramarital sexual activity are to be curbed, and "missionary position heterosexual sex with the husband" is to be promoted. It is, these authors say, the "directing [of] women's sexuality that is objectionable" (Webber and Schonfeld 2003, 66) rather than the curbing of sexuality, to which we had referred. This argument fails in a number of ways. First, it is hard to see why it is only "directing sexuality" rather than also "curbing sexuality" that is morally troubling. Second, the explanation that circumcision has been used in an attempt to direct sexuality, could as (im)plausibly be employed to explain why males are circumcised as it can to explain why females are circumcised. Indeed, as we indicated, male circumcision has sometimes been employed in an attempt to curb male sexuality, while it has also been thought to *enhance* sexual pleasure. It could be argued, that the sexuality of males has been directed, even if not in exactly the same way, that the sexuality of females is alleged to be directed. The point is not that female sexuality has not been controlled and directed, but that the evidence does not suggest that the practice of *circumcision* (understood as the removal of preputial tissue) is any more directive of women's sexuality than it is of men's.

The third problem with the argument of Professors Webber and Schonfeld is that even if circumcision had been used *in a bid* to direct female but not male sexuality, it would not follow that different moral judgments could be made about physically analogous male and female circumcision, particularly if two conditions were met: (a) neither the male nor female form *actually* had any effect on sexuality; and (b) neither male nor female circumcision, in the given instances, were employed in the hope of directing sexuality. We have suggested that condition (a) is true. Instances of male and female circumcision performed by people recognizing the truth of condition (a) would satisfy condition (b). Professors Webber and Schonfeld might respond that it is the *historical* purpose of circumcision, rather than the purpose of any given circumcision that is relevant. But on this argument, currently innocuous practices are tainted for all eternity if they once had an odious foundation.

A Catholic debate

John Paul Slosar and Daniel O'Brien very helpfully showed how our arguments are compatible with the best Catholic thinking about circumcision. Petrina Fadel takes them to task for looking to non-Catholics "for guidance" instead of following (her view of) Catholic teaching. While we do not wish to enter a debate around what the correct Catholic view is on circumcision, there are numerous weaknesses in Ms. Fadel's response to Drs. Slosar and O'Brien, which require no special knowledge of Catholic teachings to recognize. First, she employs the very rhetoric against which we cautioned and carefully argued. For instance, she cavalierly describes circumcision as "amputation" (Fadel 2003, W-1) and "mutilation" (Fadel 2003, W-2). She liberally disburses anecdotes (Fadel 2003). She appeals to those authorities who support her view (Fadel 2003), and leaves critical readers wondering how representative these interpretations of the relevant teachings are in Catholicism. These readers will not be content with her assurance that she is "certain" that she is "interpreting the genuine sentiment of every upright conscience" (Fadel 2003, W-2). Such talk is crude rhetoric, not the sort of reasoned argument we expect to see in an academic journal.

Any Catholic judging circumcision to be *immoral* would have to explain how God could have once *commanded* (some) people to circumcise their sons, something which Catholics must surely believe given that they accept what they call the Old Testament. Even if one believes that the covenant of the circumcision has been superceded and that circumcision is no longer required, Catholics opposed to circumcision need to explain how God could have commanded what they take to be immoral. Ms. Fadel offers us no such explanation. She does note (correctly) that ancient Hebrew circumcision (which would have been performed on Jesus) involved removal of less of the foreskin than contemporary Jewish circumcision. But given Ms. Fadel's arguments about circumcision, it is hard to see how she could think that even this more limited form of circumcision is morally permissible. Thus she needs to explain how God could have commanded a form of circumcision she takes to be immoral.

Other problems

The responses of our critics abound with other defects. We cannot list them all, but we shall provide a few examples.

Rio Cruz and colleagues offer us a non sequitur. They say that to reach our conclusion that circumcision is morally permissible, we ignore the fact that, worldwide, circumcision is relatively rare (Cruz et al. 2003). But the rarity of a practice is utterly irrelevant to determining its moral permissibility. Worldwide, baseball is rare, but that does not make it immoral.

These same authors also offer appeals to authority. For example, they say that forced "male circumcision has been recognized as a human rights violation in at least one legal case and in two United Nations reports" (Cruz et al. 2003, W-1). But moral arguments cannot be settled by appealing to legal judgments and United Nations reports. And if one

could, it would be far from clear that merely one legal case and two United Nations reports would establish the conclusion.

Wayne Hampton is prone to a crude relativism. He says that we “neglect the fact that child abuse is not an objective interpretation, but a subjective one” (Hampton 2003, W-1). Now, insofar as that is true, he has no moral complaint against those who circumcise. *He* might take this practice to be child abuse, but if what constitutes “child abuse” is merely a matter of subjective interpretation he has no grounds for criticizing those circumcisers who deny that circumcision is child abuse.

In a non-relativist moment, he assures us that there “is a whole website devoted to cataloging bad reasons for circumcision” (Hampton 2003, W-1). Only the most naïve readers will be impressed by this. There are whole websites devoted to holocaust denial, various conspiracy theories and dozens of other crackpot views. The mere existence of these websites and the “evidence” they list, provides us with no reason to accept their claims. There is no substitute for examining the actual evidence, as found in peer-reviewed papers.

George Hill does not distinguish causation from relationships such as correlation and mere coincidence. In support of his claim that circumcision impedes intromission and intra-vaginal penile gliding, he notes that “the sale of sexual lubricants” in the United States “far exceeds that in countries where routine non-therapeutic circumcision is unknown” (Hill 2003, W-1).

A number of our commentators employ inflammatory rhetoric. For example, Petrina Fadel compares the research use of circumcised prepuces with the Nazi use of Jewish skin to make lampshades (Fadel 2003). But there is a vast moral difference between using surgical waste for research and making lampshades out of somebody one has murdered.

Numerous of our respondents provide tendentious formulations of their arguments and beg the question. Wayne Hampton, for example, says that “conformity, anatomic incorrectness, chastity enforcement, false ideas about how men are made ... conflict with real human values such as autonomy, wholeness, human dignity, and so on” (Hampton 2003, W-2). Paul Ford describes circumcision as a “type of barbarism”, lumping it together with penile bifurcation (Ford 2003, 58). Rio Cruz and colleagues proclaim that we “conclude that amputating normal, natural, protective, and sexually important tissue from a non-consenting infant does not constitute abuse” (Cruz, 2003, W-1). None of these formulations are helpful. They assume the very conclusions for which the authors need to argue.

Conclusion

While we welcome the great deal of attention our paper has received, we find it regrettable that so many of our respondents discuss the issues as emotively as they do. What is needed when engaging this and other topics about which people feel strongly, is a cool and impartial examination of the evidence and a careful analysis of the issues

and arguments. There has been all too little discussion of circumcision in the bioethics literature and we sought to alter that. It is important, however, that the discussion meet rigorous quality standards.

Circumcision, we argued, is a permissible practice, suitably subject to parental discretion. However, we suggested that the way it is currently performed – namely without (appropriate) analgesia – is morally unacceptable. Opponents of current circumcision practices would be on strong ground if they restricted their opposition to this feature of the practice¹⁰.

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